

Henderson Healthcare Limited - Edmonton Meadows Rest Home

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Henderson Healthcare Limited

Premises audited: Edmonton Meadows Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 26 February 2018 End date: 27 February 2018

Proposed changes to current services (if any): A partial provisional audit was completed 2 October 2017 to review the services readiness to provide hospital (geriatric and medical) level of care. All 48-current rest home level rooms, will become dual-purpose rooms. HealthCERT letter dated 2 November 2017 confirmed amended certificate includes hospital (medical and geriatric) level care. The service has recently signed out 'prior to occupancy' findings from their partial provisional audit and therefore (to date) have not commenced providing hospital level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Edmonton Meadows is currently certified to provide hospital (geriatric and medical), rest home and dementia level care for up to 60 residents. On the day of audit there were 50 residents. The service is currently not providing hospital level care.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

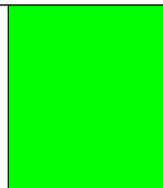
There is a full time clinical nurse manager and a facility manager (non-clinical) who manage the facility. The clinical nurse manager who has ten years' experience in the NZ aged care industry has been in this role since May 2017. The facility manager has been in this role for 23 years. Further support is also provided by two directors, an external aged care consultant, registered nurses and care staff.

Residents and family members interviewed praised the service for the support provided.

Improvements are required around implementation of the quality programme and medication documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

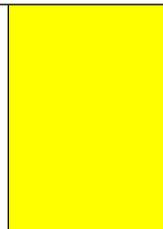


Standards applicable to this service fully attained.

The staff at Edmonton Meadows ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of low risk.

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan and quality plan have goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home level needs. This includes updates around interRAI requirements and a documented quality and risk management programme that includes analysis of data.

Ongoing training is provided and there is a training plan developed and commenced for 2018. Rosters and interviews indicate sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The clinical nurse manager provides oversight of clinical components of care. The clinical nurse manager and another registered nurse both trained in completion of interRAI assessments are responsible for the completion of assessments with each resident having a current interRAI assessment. Care plans are documented and reviewed at least six monthly and as changes occur.

Planned activities are appropriate to the residents assessed needs and abilities including activities for residents in the dementia unit or for those identified as younger. Residents and family expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or as when necessary according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs catered for. Residents and family confirmed that adequate fluids and food are provided, and snacks are available between meals or whenever needed. The facility utilises a four-weekly rotating menu with these recently reviewed by a dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is in place and a New Zealand Fire Service evacuation scheme is approved. A maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Rooms are personalised with resident belongings.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

There is a secure dementia unit that has specifically identified indoor and outdoor areas for residents.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a documented policy around restraint minimisation and use of enablers. A policy around management of challenging behaviours is documented. There is one resident using a bedrail identified as a restraint and no enablers at the time of the audit. Staff interviewed demonstrate an understanding of restraint and enabler use and receive ongoing restraint education. Use of the restraint is monitored as per policy.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control coordinator (the clinical nurse manager). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	2	0	0	0
Criteria	0	98	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with staff (four caregivers, two registered nurses, and two activities officers) confirmed their familiarity with the Code. Six rest home residents and five family members (three rest home and two dementia) interviewed, confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident's record reviewed. Forms are signed and dated appropriately. The admission agreements were signed and dated by the provider and the resident and/or representative. EPOAs are activated on dementia resident files. The GP interviewed understood the obligations and legislative requirement to ensure competency of residents, as required for advance directives and advance care planning. Resident reviews were undertaken six monthly. Reviews of the individual resident's health status was documented and retained in each personal file reviewed. There are policies in place for informed consent and resuscitation and the service is committed to meeting

		<p>the requirements of the Code of Health and Disability Services Consumers Rights. Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p> <p>Discussion with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available around the facility. Advocacy services visit twice a year and on request. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions. The service has links to the local Alzheimer's Society, which provides support for those who have dementia or have a loved one with a diagnosis of dementia.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility. The one resident on the YPD contract and the respite resident are engaged in a range of community activities.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at reception. The residents interviewed were aware of the complaints process and to whom they should direct complaints. The service had two complaints in 2017 and have had no complaints in 2018 to date. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed have been followed up and implemented. Residents advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and families interviewed identified they are well-informed about the Code. Surveys and direct communication with management provide the opportunity to raise concerns. Advocacy and Code of Rights</p>

Consumers are informed of their rights.		information is included in the information pack and are available at the service. Information leaflets from the Alzheimer's society are also available.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is a policy on abuse and neglect and staff received training in February 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were two residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. The service has developed a relationship with Waipareira Trust Marae and can call on WDH B Māori liaison service for assistance or advice when required. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff have had training around cultural safety.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs.
Standard 1.1.7: Discrimination	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>induction includes an emphasis on privacy and personal boundaries. The staff employment process includes the signing of house rules.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home or dementia level care (noting, they have not yet implemented hospital level care. The service has policies and procedures, equipment, and transition plan to support implementation of hospital level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility). Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Integrated quality/management and staff meetings are conducted. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers complete competencies relevant to their practice. Under the new ownership, the service has made a point of improving communication with staff, residents and families through meetings and an open-door policy. Interviews confirmed this. A focus of the new ownership has been increasing the skill level of all staff - care staff are encouraged to undertake careerforce studies and staff (RN and HCAs) have attended external education on palliative care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated their relatives are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings have occurred regularly, and the clinical nurse manager and facility manager have an open-door policy. Aged care residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>Edmonton Meadows is an independently owned service that currently provides rest home and dementia level care for up to 60 residents. The service completed a partial provisional audit in October 2017 to add hospital (geriatric and medical) level care. HealthCERT letter dated 2 November 2017 confirmed amended certificate includes hospital (medical and geriatric) level care. The service has only recently signed out 'prior to occupancy' findings from their partial provisional audit and therefore (to date) have not commenced providing hospital level of care.</p>

<p>consumers.</p>		<p>There is a 12-bed dementia unit, and three 16-bed rest home wings. On the day of audit there were 11 dementia level care residents (including one respite contract) and 38 (including one younger person on a POAC (primary options for acute care contract), one YPD contract, and one respite) rest home residents and one hospital level care resident (dispensation letter dated 22 December 2017).</p> <p>The directors who own another facility have owned Edmonton meadows since purchasing in May 2017. They are fully informed of all aspects of the service at weekly meetings and attend integrated quality management meetings bi-monthly. One or both directors visit at least weekly and both are on call at all times. The clinical nurse manager is supported by a facility manager (non-clinical), each work fulltime and a team of registered nurses and healthcare assistants. The facility manager has 23 years' experience at Edmonton meadows with eight years as manager. There is a registered nurse on-site 24/7.</p> <p>The goals and direction of the service and the proposed transition to include hospital level are well documented in the business plan and the progress toward goals has been documented.</p> <p>The clinical nurse manager and facility manager have completed eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the facility manager, the clinical nurse manager with the support the directors, fill the role. During the temporary absence of the clinical nurse manager, a senior registered nurse fills the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>There is a current quality risk management plan. Staff interviewed could describe quality data collected and fed back to them through meetings. The clinical nurse manager facilitates the quality programme.</p> <p>There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered and these are reviewed and updated at least two yearly or sooner if there is a change in legislation, guidelines or industry best practise.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include (but not limited to) internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at monthly staff</p>

<p>principles.</p>		<p>meetings and integrated bi-monthly quality management meetings. Meeting minutes reviewed did not evidence discussion and feedback of internal audit outcomes. Resident meetings have been held regularly. There are resident/relative surveys conducted and analysed. The last survey was September 2017 and the outcome of the survey identified that those who responded were very satisfied with the service provided.</p> <p>Corrective action plans are developed and implemented when service shortfalls are identified. Correctives actions have not been signed off as completed</p> <p>Hazards are identified, managed and documented on the hazard register. There is a designated health and safety officer. Health and safety issues are discussed at monthly quality/staff meeting with action plans documented to address issues raised.</p> <p>A post-falls assessment is completed for every fall and prevention strategies are in place for individual residents.</p> <p>The service has included benchmarking against other similar facilities in their quality plan for the year. This is an initiative under the new ownership. The CNM confirmed data collection has commenced.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Fourteen incidents (all incidents from February 2018 to date) demonstrated appropriate documentation and clinical follow-up. Accidents and incidents are analysed monthly with results discussed at the integrated quality management and staff meetings.</p> <p>The management team are aware of situations that require statutory reporting. No events have required reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files sampled (the clinical nurse manager, a registered nurse, the chef, a kitchenhand the activities coordinator and two healthcare assistants), evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has employed additional RN's to provide clinical cover 24/7. Staffing is sufficient to provide hospital level care.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately</p>

		<p>orientated to the service. There is an annual education plan being implemented that includes competencies that must be completed by staff. Two of five RNs have completed their interRAI training. The orientation package provides information and skills around working with residents with rest home and dementia level care needs and were completed in all staff files sampled. Care staff who work in the dementia unit have completed the required dementia training modules.</p> <p>Residents stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the clinical nurse manager who works full-time, there are five full-time RNs employed covering all shifts. There is an on-call system with the CNM, the FM and both directors available at all times. The RNs are supported by healthcare assistants, designated laundry and housekeeping staff. Healthcare assistants assist the designated laundry staff. Cleaning staff are employed over seven days a week. An activities coordinator is rostered Monday to Friday with an activities assistant working one day (four hours) on the weekends. Staff reported that staffing levels and the skill mix were appropriate and safe.</p> <p>Edmonton Meadows is divided into four wings. On the day of audit, the yellow dementia wing had eleven residents and each of the three rest home wings (blue green and white) had either twelve of thirteen residents. There is one RN on duty on each shift with the clinical nurse manager providing support Monday to Friday. The RNs are supported by adequate numbers of HCAs. In the dementia unit, there are two HCAs on duty in the morning and two HCAs on the afternoon shift and one on the night shift. In each of the rest home wings there is one HCA on duty on the morning and afternoon shifts with one HCA covering the night shift. There is evidence of team work and staff assisting across the wings as required.</p> <p>Staff, residents and relatives interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so.</p> <p>Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner as described by residents interviewed. Information packs are provided for families and residents to the service and this includes information around the dementia unit.</p> <p>The facility requires all residents to have needs assessment service coordinator (NASC) assessments via an interRAI assessment, prior to admission, to ensure they can meet the resident's needs. All resident records reviewed as part of the selected sample had a needs assessment completed prior to admission. One resident has been assessed as requiring hospital level care and a dispensation has been approved by the Ministry of Health on 22 December 2017.</p> <p>Interviews confirm that the registered nurse or the clinical manager admits new residents into the facility. A review of resident records confirms that admission records are completed with an electronic register of residents retained.</p> <p>The registered nurse receives handover from the transferring agency, for example, the hospital at the district health board, and utilises this information in the development of the care plan for the resident. Any records from a transferring agency are retained in the resident record.</p> <p>Family are encouraged to be a part of the admission and entry process with this confirmed by family interviewed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge, or transfer of residents are undertaken in a timely and safe manner. The clinical nurse manager reports that they include copies of the resident's records including: general practitioner visits; medication charts; current long-term care plans; upcoming hospital appointments; and other medical alerts, when a resident is transferred to another health provider.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. The service uses an electronic system for prescribing and administration of medication for most residents. Some residents elect to have their own doctor and at times, the doctor is not linked to the electronic database. In these instances, there are also copies of the prescription on record and a pharmacy documented administration signing form. The medication areas are free from heat, moisture, and light, with medicines stored in original dispensed packs, in a secure manner.</p> <p>Sixteen medicine charts reviewed met legislation and allergies documented. All residents have photo identification with confirmation that the photograph is a true likeness. Two residents using respite services do</p>

		<p>not have a photograph on the medication file, however, staff are able to describe ways that they identify the resident. Discontinued medicines are identified. The three monthly or 'as required' general practitioner reviews are all completed within the three-monthly timeframe. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored weekly.</p> <p>Medication administration was observed during lunch time. Medication administration practice met medication guidelines.</p> <p>Stocktakes of controlled drugs are not documented as completed weekly</p> <p>Staff are authorised to administer medications with competencies completed annually. There are residents who self-administer medicines with a competency completed. Each resident is confirmed as having a safe secure place to store medications if they self-administer. A resident who self-administers medication confirms that staff check daily to ensure that they have remembered to take the medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service policies and procedures are appropriate to the service setting, with a four-weekly menu reviewed by a dietitian in January 2018. Residents' dietary profiles are developed on admission with a current list of likes, dislikes and allergies maintained on a whiteboard in the kitchen. Dietary profiles are updated as required and at least six monthly in line with the completion of the interRAI assessment. Interviews with the chef confirm their awareness of the residents' dietary requirements. Kitchen staff are trained in safe food handling processes. Food safety procedures are adhered to as observed during the audit.</p> <p>Residents who require special dining aids are provided for, to promote independence. The residents' files demonstrated monthly monitoring of individual resident's weight with any weight loss reported and measurement of weight increased to weekly. Supplements are provided to residents with identified weight loss.</p> <p>Residents state they are satisfied with the food service and family for residents in the dementia unit state that they are happy with meals and service provided. Residents reported their individual preferences are met and adequate food and fluids are provided. Food on the days of audit was hot and met assessed resident needs. The service provides additional food over a 24-hour period for residents in the dementia and for others in the service if they require snacks outside of meals and morning/afternoon tea times.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines.</p>
Standard 1.3.2: Declining	FA	The service has a documented process for the management of declining residents' entry into their care.

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services. In general, potential residents are not declined as all have a needs assessment completed prior to entry.</p> <p>The scope of services provided is identified in the NASC assessment and communicated to prospective residents and their families. The clinical manager assesses the suitability of residents with support and input from the facility manager.</p> <p>When residents are not suitable for placement at the service, the family and/or the resident are referred to other services, depending on their level of needs with NASC services informed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The registered nurse or the clinical nurse manager completes a variety of risk assessment tools on admission; six monthly and as required. The service completes interRAI assessments for new residents with records reviewed confirming that these were completed in a timely manner.</p> <p>A medical assessment is completed by the general practitioner and recreational assessment completed by the activities coordinator. Baseline recordings are recorded for weight management and vital signs at least monthly. If a resident is identified as having weight loss, then the weight is taken weekly as sighted in two resident records reviewed.</p> <p>The needs, support requirements, and preferences are collected and recorded for residents with the long-term care plan aligning with the interRAI assessment.</p> <p>Staff interviews confirm that the families are involved in the assessment and review processes with family or the resident signing on the care plan to indicate their involvement. The outcomes of the assessments are used in creating an initial care plan and in the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The care plans are resident focused for a resident requiring hospital level of care; dementia unit and rest home and describe in-depth strategies for meeting goals.</p> <p>The residents' files have sections for the resident's profile, details, observations, care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals are realistic, achievable, and clearly documented. The service records interventions for the achievement of the goals.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>Residents' state that they receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the care plan documented for each</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>individual resident. Residents' files reflect residents and family involvement in the development of goals and review of care plans.</p> <p>Interview with the general practitioner confirms clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plans such as discussions with the needs assessment service coordinators (NASC); podiatrist and the physiotherapist.</p> <p>There are currently two residents with a skin tear requiring dressing and two residents with a chronic ulcer. Three residents with a wound were reviewed. Both had a comprehensive assessment and progress notes documented. A wound management plan is documented for each wound or skin tear with reviews completed.</p> <p>Appropriate monitoring tools are in use as per resident need. These include turning charts, food and fluid charts and behavioural monitoring charts as per individual need and as identified in care plans.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programmes confirm that independence is encouraged, and choices are offered to residents. There are two activities coordinators (one full time and one who works seven days a fortnight). The clinical nurse manager is also a trained diversional therapist and provides oversight of the programme. The clinical nurse manager and activities coordinators develop the plan, and this is implemented with flexibility to consider needs of residents on the day and weather.</p> <p>Activities are held specifically in the dementia unit as well as in the rest home area. Individual activities are documented for the resident accessing hospital level of care as they are not able to engage in group activities. Individual activities are also offered to other residents who do not wish to engage in group activities. Activities plans include relevant cultural activities.</p> <p>An activities plan is documented for each day/week and displayed in the rest home and dementia unit for residents and family to view. Activities include (but not limited to): physical; mental; spiritual and social aspects of life, to improve and maintain residents' wellbeing. During the on-site audit, activities included: residents walking; music; crafts; quizzes and exercise. One-to-one activities were also observed to be offered. Residents and family confirm they are satisfied with the activity programmes including one resident interviewed who identified as being under the age of 65 years.</p> <p>On admission, the activities coordinator completes an activities assessment for each resident. Resident records reviewed during the on-site audit included an assessment, plan, and documentation of review of the plan. Each plan is reviewed six monthly in conjunction with completion of the interRAI assessment. A daily log of attendance is completed. Residents in the dementia unit have a detailed 24-hour activity care plan documented that links to the long-term care plan. Staff can describe interventions as per the 24-hour plan and describe providing activities in the unit.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The four long-term care plans reviewed (two rest home including one YPD; one hospital and one dementia resident) had been evaluated by the registered nurses six-monthly or when changes to care occurs. All long-term care plans reviewed had a documented evaluation completed. The two rest home short-stay resident files reviewed (one respite, one POAC) had been evaluated on a daily basis as identified in progress notes. Short-term care plans reviewed for short term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Long term care plans reviewed evidenced updates to the care plan where health status had changed. Activities plans are in place for each resident and these are also evaluated six-monthly. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The clinical nurse manager states that residents are supported in access or referral to other health and disability providers. The registered nurses manage referrals for residents to the GP; dietitian; physiotherapist and mental health services. The general practitioner confirmed involvement in the referral processes. The review of residents' files included evidence of recent external referrals to the physiotherapist, podiatrist, wound and other specialists from the district health board.</p> <p>Members of the allied health team document in the resident record. The physiotherapist visits the service as required and the podiatrist provides a service six weekly.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures for the management of waste and hazardous substances that have a focus on risk management. Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services. Personal protective equipment for staff is readily available and adequate supplies are maintained for daily use and for use in an emergency.</p> <p>The auditors were requested to review the availability of sluice rooms following the partial provisional audit. A second sluice has been added to the rest home area to ensure that there are sufficient resources to provide hospital level care. Staff interviewed state that they are required to put a lid on any bucket being taken to the sluice room and they know that they are not able to transport any bucket containing material that requires sluicing during meal times or while activities are occurring. The clinical nurse manager monitors compliance with instructions and policy.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current warrant of fitness. A fire evacuation scheme is in place and signed by the New Zealand Fire Service.</p> <p>The rest home has a number of wings that merge into a central lounge/dining area. The dementia unit is a secure unit under the same roof as the rest home. Planned and reactive maintenance is implemented by the maintenance person and contractors.</p> <p>There is a maintenance staff member with contractors used as required. There are processes for documenting any issues identified with this signed off when completed. There is a preventative maintenance plan in place with this implemented. Staff state that there is sufficient equipment, and this was observed during the audit.</p> <p>The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents. The electrical equipment is checked, and records maintained. Testing and calibration checks of medical measuring equipment occurs annually. The hot water temperatures at the taps in resident areas are checked monthly by the maintenance person and temperatures maintained at 45 degrees Celsius or just below.</p> <p>The service has vehicles used for transporting residents. There is a system for managing the vehicle warrant of fitnesses and current registrations.</p> <p>There are outdoor areas available for all residents including verandas and outdoor garden areas in the secure dementia unit and out of the rest home area.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient toilets, hand basins and showering facilities available for residents. All rooms have hand basins in their room with some rest home rooms having ensuite. The rest home rooms are large enough to take residents requiring hospital level care with wide doorways and double doors into showers. The dementia unit has communal toilets with combined showers.</p> <p>There are appropriate privacy protections in place when showers and toilets are in use.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents have their own room. Bedrooms in the rest home wings are large enough to cater for residents requiring hospital level care. There are wide doorways and rooms can include two staff or more caring for a resident and to allow for an emergency equipment or a hoist if required. There is ample room for mobility aides to be used safely in each resident's room.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge in the rest home and a lounge that caters for all residents in the dementia unit. There are smaller rooms available throughout the building with comfortable seating for family/visitors and group meetings. The lounges are also used for activities. Each area (rest home area and dementia unit) has a dedicated dining room area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are laundry policies available. The cleaner and laundry staff interviewed confirmed their practice as per policy.</p> <p>The service employs cleaners seven days a week. There is adequate storage for all chemicals in locked designated areas. There is a cleaning schedule in place with documented daily cleaning tasks to be completed. Laundry is performed by dedicated staff seven days a week. There is a large laundry on-site that contains a commercial grade washing machine and a clothes dryer. There is a smaller washing machine used by some residents so that they retain their independence. The clinical nurse manager monitors use. There is an outside washing line which is used as much as possible. There is dirty and clean separation in the laundry.</p> <p>There are material data sheets available for all chemical products used for cleaning and the laundry. The clinical nurse manager monitors the cleaning and laundry service through the internal audit programme to ensure resident and relative satisfaction is maintained.</p> <p>Residents and relatives interviewed confirm satisfaction with the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	<p>FA</p>	<p>There is an approved evacuation scheme. Evacuation drills occur at least six monthly with the results of these documented. All staff have completed education on emergency management. There is a staff</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>member on duty 24/7 with a current first aid cert,</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water and blankets. Food dry stock and frozen food are available to support residents for at least three days. There is sufficient drinking water on-site to support the maximum number of residents on-site for at least three days.</p> <p>An electric call bell system is available throughout the units. The call bells from the dementia unit can be monitored by the rest home as well as in the dementia unit. Security is maintained. The dementia unit is secured with key pad entry. A perimeter fence around the dementia unit is erected and gates are locked. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately.</p> <p>Closed circuit television has been installed in hallways and main areas such as lounges and dining areas. These are able to be monitored in the facility managers office. The clinical nurse manager states that there are notices informing visitors of the cameras and information is only used to ensure that residents are safe.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms have an external window, and some have shutters that can be opened for ventilation. The buildings are ventilated by opening windows and doors and extraction systems.</p> <p>Heating is managed throughout the facility to ensure that there is a constant temperature appropriate to the needs of residents. Fans are also available in hot weather.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Edmonton Meadows has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager is the designated infection control person with support from all staff. Infection control matters are routinely discussed at all quality/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. The CNM is responsible for infection prevention and control. The infection control team is all staff through the quality management and staff meetings. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The staff orientation programme includes infection control education. The infection control coordinator has completed external infection control training and updates. Infection control education for staff last occurred in September 2017. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of</p>

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month-by-month. Infections are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. The infection rate is low and there have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Staff interviewed, observations, and review of documentation, demonstrated safe use of restraint or enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a restraint register. There is one resident using restraint in the rest home (a resident requiring hospital level of care using a bedrail). There are no enablers being used in the facility. The restraint coordinator is the clinical nurse manager.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment, which is then discussed with the general practitioner and family prior to commencement of any restraints. The restraint committee is defined in the restraint minimisation and safety policies and procedures. The duration of each restraint is documented in the restraint plans of residents. Caregivers who are overseen by the registered nurse are responsible for monitoring and completing restraint forms when the restraints are in use.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include restraint related risks. The service records underlying causes for behaviour that requires restraint with a focus on culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records. The file reviewed for a resident using restraint confirms that a comprehensive assessment is completed.
Standard 2.2.3: Safe	FA	Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of sensor mats. Restraint consents are signed by the general

<p>Restraint Use</p> <p>Services use restraint safely</p>		<p>practitioner, family, and the restraint coordinator. Restraints are incorporated in the long-term care plans and reviewed at least six monthly. The restraint register is up-to-date.</p> <p>The file reviewed where the resident was using restraint included documentation of risks around restraint and safe ways for the restraint to be used.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and includes restraint minimisation reviews. There are corrective actions put in place when issues are identified. Staff knowledge and good practice is included in the quality reviews.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>There is a bi-monthly quality/management meeting and a separate bi-monthly staff meeting to which all staff are invited. Aspects of the quality programme include (but not limited to): complaints, internal audits, health and safety, accidents and incidents, infections and risk management are discussed and documented in meeting minutes. Internal audits and annual survey results are an agenda item for meetings. Resident meetings are held. Small resident and staff numbers and open discussion mean issues are discussed with management as they arise.</p>	<p>The combined quality/management and staff meeting minutes reviewed did not reflect discussion around internal audits outcomes.</p>	<p>Ensure internal audits and corrective actions are discussed in quality/management and staff meetings and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified</p>	PA Low	<p>Internal audits and surveys are completed as scheduled and corrective actions are documented on a summary page attached to the audit results. The corrective action plan details requirements and responsibilities and required timeframes. Corrective actions arising from complaints are documented. Corrective actions are documented as implemented but not all signed out as completed.</p>	<p>Seven of seven corrective actions reviewed were documented and evidence implementation of corrective actions</p>	<p>Ensure corrective action plans evidence completion.</p>

Standard or requirements is developed and implemented.			but have not been signed out as completed.	90 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Sixteen medicine charts reviewed met legislation and allergies documented. All residents have photo identification with confirmation that the photograph is a true likeness. Two residents using respite services do not have a photograph on the medication file, however, staff are able to describe ways that they identify the resident. Discontinued medicines are identified. The three monthly or 'as required' general practitioner reviews are all completed within the three-monthly timeframe. Stocktakes of controlled drugs is currently being completed fortnightly.	Stocktakes of controlled drugs are not occurring weekly.	Ensure that stocktakes of controlled drugs occurs weekly. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.